FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045492

Facility Name: EAST PEORIA GARDENS HEALTHCARE CENTER

Address: 1910 SPRINGFIELD ROAD (Number) EAST PEORIA (City) 62301 (Zip Code)

County: TAZWELL

Telephone Number: (847) 694-1435 **Fax #** (847) 694-1475

IDPA ID Number: 36-4420686

Date of Initial License for Current Owners: 10/01/01

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	103	Intermediate (ICF)	103	37,595	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	103	TOTALS	103	37,595	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,978	1,978	8
9	SNF/PED					9
10	ICF	23,228	1,618		24,846	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,228	1,618	1,978	26,824	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.35%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/01

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/01/01 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 1,978

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	134,810	12,364	5,866	153,040		153,040		153,040			1
2	Food Purchase		122,837		122,837		122,837	(369)	122,468			2
3	Housekeeping	80,479	10,309		90,788		90,788		90,788			3
4	Laundry	38,060	6,835	137	45,032		45,032		45,032			4
5	Heat and Other Utilities			88,585	88,585		88,585	28	88,613			5
6	Maintenance	27,564	16,702	21,550	65,816		65,816	3,590	69,406			6
7	Other (specify):*			9,517	9,517		9,517	22	9,539			7
8	**TOTAL General Services**	280,913	169,047	125,655	575,615		575,615	3,271	578,886			8
	B. Health Care and Programs											
9	Medical Director			9,500	9,500		9,500		9,500			9
10	Nursing and Medical Records	762,121	39,437	4,839	806,397		806,397	16,867	823,264			10
10a	Therapy	32,897	3,840	68,558	105,295		105,295	(724)	104,571			10a
11	Activities	37,362	2,873		40,235		40,235		40,235			11
12	Social Services	38,915		3,300	42,215		42,215		42,215			12
13	CNA Training											13
14	Program Transportation			10	10		10		10			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	871,295	46,150	86,207	1,003,652		1,003,652	16,143	1,019,795			16
	C. General Administration											
17	Administrative	51,800			51,800		51,800	52,872	104,672			17
18	Directors Fees											18
19	Professional Services			50,530	50,530		50,530	2,712	53,242			19
20	Dues, Fees, Subscriptions & Promotions			18,162	18,162		18,162	(3,680)	14,482			20
21	Clerical & General Office Expenses	90,996	10,251	144,893	246,140		246,140	(98,077)	148,063			21
22	Employee Benefits & Payroll Taxes			194,530	194,530		194,530		194,530			22
23	Inservice Training & Education			906	906		906	730	1,636			23
24	Travel and Seminar							142	142			24
25	Other Admin. Staff Transportation			641	641		641	1,618	2,259			25
26	Insurance-Prop.Liab.Malpractice			72,874	72,874		72,874	821	73,695			26
27	Other (specify):*							31,768	31,768			27
28	**TOTAL General Administration**	142,796	10,251	482,536	635,583		635,583	(11,094)	624,489			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,295,004	225,448	694,398	2,214,850		2,214,850	8,320	2,223,170			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: EAST PEORIA GARDENS HEALTHCARE CENTI #0045492 **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,535	
	REPAIRS & MAINTENANCE		331	
			0	5,866
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		137	
			0	137
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		34,641	
	ELECTRICITY		23,859	
	WATER		20,855	
	CABLE TV - LOBBY		9,230	
			0	88,585
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,345	
	PAINTING & DECORATING		427	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		9,234	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,925	
	FIRE SERVICE		6,619	
			0	
			0	
			0	21,550
7	**OTHER**			
	SCAVENGER		9,517	
	SECURITY SERVICE		0	9,517
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,500	9,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		1,294	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	3,545	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	4,839
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		1,697	
	SPEECH THERAPY SERVICES		1,562	
	OCCUPATIONAL THERAPY SERVICES		81	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	THERAPY CONTRACT SERVICES		54,418	68,558
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,300	
			0	3,300
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER #0045492 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		10	10
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	9,741	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	40,789	
			0	50,530
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,192	
	EMPLOYEE WANT ADS	XIX F	10,716	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	348	
	LICENSES & PERMITS	XIX F	1,295	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	4,079	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	500	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	32	18,162
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		5,189	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	21,148	
	HOME OFFICE EXPENSE		109,276	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		9,199	
	MESSENGER SERVICE		81	
			0	144,893

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	97,350	
	UNEMPLOYMENT COMPENSATION	XIX D	52,425	
	WORKERS COMPENSATION INSURANCI	XIX D	41,907	
	HOSPITALIZATION INSURANCE	XIX D	2,700	
	EMPLOYEE BENEFITS - OTHER	XIX D	148	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	194,530
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		906	906
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		641	641
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		72,874	72,874
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 694,398

EAST PEORIA GARDENS HEALTHCARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	122,837	PATIENT MEALS	80472
LESS SALES TAX	(369)	ADD EMPLOYEE MEALS	0
NET FOOD	122,468	TOTAL MEALS/YEAR	80472
TOTAL PATIENT CENSUS	26,824	NET FOOD	122468
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	80472
TOTAL PATIENT MEALS	80472	COST PER MEAL	1.52
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER #0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			10,527	10,527		10,527	32,390	42,917			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			51,373	51,373		51,373	78,161	129,534			32
33	Real Estate Taxes			26,668	26,668		26,668		26,668			33
34	Rent-Facility & Grounds			42,296	42,296		42,296	(42,296)				34
35	Rent-Equipment & Vehicles			52,341	52,341		52,341	(37,299)	15,042			35
36	Other (specify):*											36
37	**TOTAL Ownership**			183,205	183,205		183,205	30,956	214,161			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		63,481	65,937	129,418		129,418	(6,685)	122,733			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,393	56,393		56,393		56,393			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		63,481	122,330	185,811		185,811	(6,685)	179,126			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,295,004	288,929	999,933	2,583,866		2,583,866	32,591	2,616,457			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(960)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(369)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(21,148)	21		18
19	Entertainment		20		19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(99)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(1,192)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(4,079)	20		28
29	Other-Attach Schedule	(11,942)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (40,289)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	72,880		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 72,880		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 32,591		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

EAST PEORIA GARDENS HEALTHCARE CENTER

ID# 0045492

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING SALARY	(11,942)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(11,942)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(369)	0	0	0	0	0	0	0	0	0	0	(369)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	28	0	0	0	0	0	0	0	0	28	5
6	Maintenance	0	0	3,590	0	0	0	0	0	0	0	0	3,590	6
7	Other (specify):*	0	0	22	0	0	0	0	0	0	0	0	22	7
8	**TOTAL General Services**	(369)	0	3,640	0	0	0	0	0	0	0	0	3,271	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	16,867	0	0	0	0	0	0	0	0	16,867	10
10a	Therapy	0	(2,338)	1,614	0	0	0	0	0	0	0	0	(724)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(2,338)	18,481	0	0	0	0	0	0	0	0	16,143	16
	C. General Administration													
17	Administrative	0	0	52,872	0	0	0	0	0	0	0	0	52,872	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(99)	0	2,811	0	0	0	0	0	0	0	0	2,712	19
20	Fees, Subscriptions & Promotions	(5,771)	0	2,091	0	0	0	0	0	0	0	0	(3,680)	20
21	Clerical & General Office Expenses	(33,090)	0	(64,987)	0	0	0	0	0	0	0	0	(98,077)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	730	0	0	0	0	0	0	0	0	730	23
24	Travel and Seminar	0	0	142	0	0	0	0	0	0	0	0	142	24
25	Other Admin. Staff Transportation	0	0	1,618	0	0	0	0	0	0	0	0	1,618	25
26	Insurance-Prop.Liab.Malpractice	0	0	821	0	0	0	0	0	0	0	0	821	26
27	Other (specify):*	0	0	31,768	0	0	0	0	0	0	0	0	31,768	27
28	**TOTAL General Administration**	(38,960)	0	27,866	0	0	0	0	0	0	0	0	(11,094)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,329)	(2,338)	49,987	0	0	0	0	0	0	0	0	8,320	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(960)	27,583	5,767	0	0	0	0	0	0	0	0	32,390	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	51,057	27,104	0	0	0	0	0	0	0	0	78,161	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(42,296)	0	0	0	0	0	0	0	0	0	(42,296)	34
35	Rent-Equipment & Vehicles	0	(41,080)	3,781	0	0	0	0	0	0	0	0	(37,299)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(960)	(4,736)	36,652	0	0	0	0	0	0	0	0	30,956	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(6,685)	0	0	0	0	0	0	0	0	0	(6,685)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(6,685)	0	0	0	0	0	0	0	0	0	(6,685)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(40,289)	(13,759)	86,639	0	0	0	0	0	0	0	0	32,591	45

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULED ATTACHED		CAREPLUS MGMT	SKOKIE	
				EAST PEORIA GARDENS LLC		
					SKOKIE	
				CAREPLUS REHABILITATIVE SERVICES		
					SKOKIE	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	DEPRECIATION	$	EAST PEORIA GARDENS REALTY LLC		$ 19,880	$ 19,880	1
2	V	32	INTEREST		" " "		41,280	41,280	2
3	V	34	RENT	42,296				(42,296)	3
4	V								4
5	V								5
6	V	10A	THERAPY SERVICES	68,557	CAREPLUS REHABILITATIVE SERVICES		66,219	(2,338)	6
7	V	39	THERAPY SERVICES	65,937	" " "		59,252	(6,685)	7
8	V	30	DEPRECIATION		" " "		7,703	7,703	8
9	V	32	INTEREST		" " "		9,777	9,777	9
10	V	35	EQUIPMENT RENT	41,080	" " "			(41,080)	10
11	V								11
12	V								12
13	V								13
14	Total			$ 217,870			$ 204,111	$ * (13,759)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	HOME OFFICE EXPENSE	$ 109,276	CAREPLUS MANAGEMENT INC	100.00%	$	$ (109,276)	15
16	V								16
17	V	5	ELECTRICITY		" " "		28	28	17
18	V	6	MAINT & REPAIRS		" " "		1,336	1,336	18
19	V	6	MAINTENANCE SALARIES		" " "		2,254	2,254	19
20	V	7	SECURITY		" " "		22	22	20
21	V	10	NURSING SALARIES		" " "		16,867	16,867	21
22	V	10a	THERAPY SALARIES		" " "		1,614	1,614	22
23	V	17	ADMIN SALARIES		" " "		52,872	52,872	23
24	V	19	PROFESSIONAL FEES		" " "		2,811	2,811	24
25	V	20	ADVERTISING		" " "		2,091	2,091	25
26	V	21	OFFICE EXPENSE		" " "		16,530	16,530	26
27	V	21	OFFICE SALARIES		" " "		27,759	27,759	27
28	V	23	SEMINARS		" " "		730	730	28
29	V	24	TRAVEL		" " "		142	142	29
30	V	25	TRANSPORATION		" " "		1,618	1,618	30
31	V	26	INSURANCE		" " "		821	821	31
32	V	27	EMPLOYEE BENEFITS		" " "		31,768	31,768	32
33	V	30	DEPRECIATION		" " "		5,767	5,767	33
34	V	32	INTEREST		" " "		27,104	27,104	34
35	V	35	EQUIPMENT RENT		" " "		3,781	3,781	35
36	V								36
37	V								37
38	V								38
39	Total			$ 109,276			$ 195,915	$ * 86,639	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHERWIN I RAY	ADMIN CONSULT			SEE ATTACHED			SALARY	$ 9,688	17-7	1
2	JAKOB BAKST	DIR OPERATIONS			SCHEDULES			SALARY	9,688	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 19,376		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 8320 SKOKIE BLVD
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847)329-1555
Fax Number: (847) 329-9555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY	PATIENT DAYS	553,765	13	$ 574	$	26,824	$ 28	1
2	6	MAINT & REPAIRS	PATIENT DAYS	553,765	13	27,588		26,824	1,336	2
3	6	MAINTENANCE SALARIES	PATIENT DAYS	553,765	13	46,540	46,540	26,824	2,254	3
4	7	SECURITY	PATIENT DAYS	553,765	13	444		26,824	22	4
5	10	NURSING SALARIES	PATIENT DAYS	553,765	13	348,203	348,203	26,824	16,867	5
6	10a	THERAPY SALARIES	PATIENT DAYS	553,765	13	33,317	33,317	26,824	1,614	6
7	17	ADMIN SALARIES	PATIENT DAYS	553,765	13	1,091,504	1,091,504	26,824	52,872	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	553,765	13	58,031		26,824	2,811	8
9	20	ADVERTISING	PATIENT DAYS	553,765	13	43,163		26,824	2,091	9
10	21	OFFICE EXPENSE	PATIENT DAYS	553,765	13	341,243		26,824	16,530	10
11	21	OFFICE SALARIES	PATIENT DAYS	553,765	13	573,059	573,059	26,824	27,759	11
12	23	SEMINARS	PATIENT DAYS	553,765	13	15,061		26,824	730	12
13	24	TRAVEL	PATIENT DAYS	553,765	13	2,923		26,824	142	13
14	25	TRANSPORATION	PATIENT DAYS	553,765	13	33,401		26,824	1,618	14
15	26	INSURANCE	PATIENT DAYS	553,765	13	16,951		26,824	821	15
16	27	EMPLOYEE BENEFITS	PATIENT DAYS	553,765	13	655,825		26,824	31,768	16
17	30	DEPRECIATION	PATIENT DAYS	553,765	13	119,076		26,824	5,767	17
18	32	INTEREST	PATIENT DAYS	553,765	13	559,538		26,824	27,104	18
19	35	EQUIPMENT RENT	PATIENT DAYS	553,765	13	78,057		26,824	3,781	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,044,498	$ 2,092,623		$ 195,915	25

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	HIGHLAND PARK BANK		X				$ 1,840,000	$ 1,824,886			$ 41,280	1
2	RELATED PARTY											2
3	CARE PLUS MGMT	X									25,215	3
4	TAG 18	X									1,763	4
5	CP REHAB	X									126	5
	Working Capital											
6	CAREPLUS MGMT	X		WORKING CAPITAL	DEMAND			47,207		PRIME+	51,373	6
7												7
8												8
9	TOTAL Facility Related						$ 1,840,000	$ 1,872,093			$ 119,757	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,840,000	$ 1,872,093			$ 119,757	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER **#** 0045492 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$ 25,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 25,668	2
3. Under or (over) accrual (line 2 minus line 1).	$ 668	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 26,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 26,668	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000		8
2001	23,526	9
2002	24,029	10
2003	24,566	11
2004	25,668	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME EAST PEORIA GARDENS HEALTHCARE CENTER COUNTY TAZWELL

FACILITY IDPH LICENSE NUMBER 0045492

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-05-09-102-018	NURSING HOME	$ 266.88	$ 266.88
2.	05-05-04-301-038	NURSING HOME	$ 25,340.98	$ 25,340.98
3.	05-05-04-301-036	NURSING HOME	$ 60.30	$ 60.30
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 25,668.16	$ 25,668.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		2001	$ 18,625	1
2					2
3	TOTALS			$ 18,625	3

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			2001		$ 293,875	$ 10,686	27.5	$ 10,686	$	$ 44,972	4
5					67,500	2,455	27.5	2,455		8,490	5
6											6
7	RELATED PARTY - TAG 18				30,320	777		777			7
8	RELATED PARTY - TAG 18 IMPRV				11,912	459		459			8
	Improvement Type**										
9	SPRINKLER REPAIR/ALARM PANEL			2001	33,563	1,221	27.5	1,221		4,884	9
10	FENCE			2001	6,500	236	27.5	236		944	10
11	SPRINKLE REPAIR/SMOKE DETECTORS			2002	61,025	2,219	27.5	2,219		7,859	11
12	BASEBOARD HEATING/MIXING VALUE			2002	7,621	277	27.5	277		981	12
13	ARCHITECTURAL DRAWINGS			2003	14,305	520	27.5	520		42,278	13
14	HEATING & A/C REPAIRS/SMOKE DETECTORS			2003	3,818	139	27.5	139		342	14
15	ASBESTOS CONSULTING & REMOVAL/HEATING			2004	9,396	342	27.5	342		502	15
16	AIR COMPRESSOR / BOILER			2005	19,625	327	27.5	327		327	16
17											17
18											18
19	CAREPLUS REHAB:										19
20	OFFICES, 200 WING, REHAB ROOM RENOVATION			2004	127,475	3,285	39	3,285		6,389	20
21	PAINTING, CUBICLE CURTAINS, HANDRAILS, BUMPERS			2004	48,076	1,215	39	1,215		2,363	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 735,011	$ 24,158		$ 24,158	$	$ 120,331	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTE # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 27,913	$ 1,398	$ 140	$ (1,258)	10 YRS	$ 8,856	71
72	Current Year Purchases	19,239	3,848	385	(3,463)	10 YRS	385	72
73	Fully Depreciated Assets							73
74	RELATED PARTY		14,473	18,234	3,761			74
75	TOTALS	$ 47,152	$ 19,719	$ 18,759	$ (960)		$ 9,241	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 800,788	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,877	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 42,917	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (960)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 129,572	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 52,341 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 33,265	$		$ 33,265	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,667			4,667	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			28,005			28,005	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				62,921		62,921	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB	39-3					560		560	13
14	TOTAL			$		$ 65,937	$ 63,481		$ 129,418	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER **#** 0045492 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (25,622))	349,690		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	30,740		6
7	Other Prepaid Expenses	45,411		7
8	Accounts Receivable (owners or related parties)	708,695		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,134,536	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	155,853		15
16	Equipment, at Historical Cost	47,151		16
17	Accumulated Depreciation (book methods)	(48,959)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 154,045	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,288,581	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 453,089	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	47,207		29
30	Accrued Salaries Payable	60,184		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,079		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,000		32
33	Accrued Interest Payable	3,717		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 605,276	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	600,000		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 600,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,205,276	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 83,305	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,288,581	$	48

***(See instructions.)**

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (73,055)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (73,055)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	156,360	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 156,360	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 83,305	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENT # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,740,226	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,740,226	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,740,226	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	575,615	31
32	Health Care	1,003,652	32
33	General Administration	635,583	33
	B. Capital Expense		
34	Ownership	183,205	34
	C. Ancillary Expense		
35	Special Cost Centers	129,418	35
36	Provider Participation Fee	56,393	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,583,866	40
41	**Income before Income Taxes (line 30 minus line 40)****	156,360	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 156,360	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,793	1,862	$ 51,226	$ 27.51	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,955	5,431	128,490	23.66	3
4	Licensed Practical Nurses	9,414	10,505	198,566	18.90	4
5	CNAs & Orderlies	34,243	36,657	364,959	9.96	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,156	3,295	32,897	9.98	8
9	Activity Director	2,022	2,203	24,251	11.01	9
10	Activity Assistants	1,526	1,604	13,111	8.17	10
11	Social Service Workers	3,114	3,381	38,915	11.51	11
12	Dietician					12
13	Food Service Supervisor	1,936	2,173	30,321	13.95	13
14	Head Cook	8,958	9,660	53,427	5.53	14
15	Cook Helpers/Assistants	4,399	4,874	51,062	10.48	15
16	Dishwashers					16
17	Maintenance Workers	2,529	2,797	27,564	9.85	17
18	Housekeepers	8,327	9,039	80,479	8.90	18
19	Laundry	5,102	5,601	38,060	6.80	19
20	Administrator	1,640	1,805	51,800	28.70	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,098	1,192	21,943	18.41	23
24	Clerical	4,155	4,416	69,053	15.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,896	3,229	18,880	5.85	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	101,263	109,724	$ 1,295,004 *	$ 11.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,535	1-3	35
36	Medical Director		9,500	9-3	36
37	Medical Records Consultant		0	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		3,545	10-3	39
40	Physical Therapy Consultant		5,400	10a-3	40
41	Occupational Therapy Consultant		5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		3,300	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 32,680		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTE # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAULA SCHUMAKER	ADMIN		$ 51,800
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,800

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		50,530
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 50,530

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 41,907
Unemployment Compensation Insurance		52,425
FICA Taxes		97,350
Employee Health Insurance		2,700
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		148
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 194,530

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	10,716
Health Care Worker Background Check	32
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	5,271
TRUST/FRANCHISE/CONTRIB/ETC	500
LICENSES & PERMITS	300
DUES & SUBSCRIPTIONS	348
MGMT CO ALLOCATION	2,091
TRUST/FRANCHISE/CONTRIB/ETC	(500)
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,192)
Yellow page advertising	(4,079)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,482

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	142
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 142

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$ N/A	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number EAST PEORIA GARDENS HEALTHCARE CENTER # 0045492 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **751** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. **NO**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **56,393**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees